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ABSTRACT

Housing is a critical component of community care for people with long-term mental illness. Without a place to live, the best mental health treatment and the most sophisticated rehabilitation services cannot be effective. The first phase of the deinstitutionalization movement, releasing large numbers of patients from the state hospitals and diverting admissions, has been successful. The second phase, providing for the needs of persons with mental illness in the community, has fallen short of its goal. Problems in achieving this goal have included the lack of program coordination; local problems with housing programs such as the chronic poverty of mentally ill persons; and misconceptions about the nature of mental illness. Adequate residential treatment programs for persons with mental illness should include affordable, low-income or subsidized housing; a location near support services and public transportation; a non-threatening community atmosphere encouraging independent living; and linkage to and availability of a range of services. The years to come promise to bring increased demand for services. State legislators will want to incorporate many different interests in their long-range efforts to solve the problem of housing for persons with mental illness. (Specific programmatic and legislative responses of the states are included.) (ABL)

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MENTAL HEALTH PROJECT

Human Services Series

Housing for the Mentally Ill: A Place Called Home

by

Andrea Paterson and Ellen Rhubright

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HOUSING FOR THE MENTALLY ILL: A PLACE CALLED HOME

INTRODUCTION

Housing is a critical component of community care for people with long-term mental illness. Without a place to live, the best mental health treatment and the most sophisticated rehabilitation services cannot be effective. People with mental illness have more difficulty than others finding a place to live because they suffer from severe functional disabilities and face stigma and discrimination in the community. The recurrent nature of the illness makes it difficult for them to maintain a job to pay for housing. Additionally, at different points in their lives, individuals with serious mental illness need support services to live productive lives in the community.

Yet for most persons with mental illness who live outside the hospital walls, housing is woefully scarce. Today, of the 1,635,000 individuals with serious mental illness who live in the community, only 175,000 to 300,000 live in community residential facilities, such as board-and-care homes and group homes. Between 125,000 to 250,000 are homeless. Another 1.1 million reside independently or with families, who are often poorly equipped to deal with the illness. (1)

The housing shortage contributes to homelessness and increased reliance on hospital care. Some individuals with mental illness remain in state hospitals or other restrictive settings because there is no appropriate place for them to live in the community. Similarly, many return to hospitals because the residential and support services available to them in the community have proved inadequate. Housing is key to reducing utilization of inpatient services and the problem of homelessness. For this reason, many states attempting to address housing shortages are moving beyond the traditional housing models of group, foster and personal care homes to create flexible, stable living arrangements coupled with supportive services.

GENERAL OVERVIEW

Historical Perspective: Housing Shortages and Shortfalls from the Beginning. Many think that the problems states face caring for and treating persons with mental illness have been caused by the deinstitutionalization policies of the 1960s and 1970s. The first phase of the movement--releasing large numbers of patients from the state hospital and diverting admissions--has been successful. In the past 30 years, the number of state mental hospital residents has decreased by 80 percent (2, p.1.). However, the second phase of deinstitutionalization--providing for the needs of persons with mental illness in the community--has fallen short of its goal.

One of the roadblocks preventing the successful reintegration and community-based treatment of individuals with serious mental illness thus far has been and continues to be the lack of appropriate housing. Many problems have complicated the achievement of this goal.

To begin with, community-based housing programs fell victim to the same coordination problems that generally plagued deinstitutionalization efforts.

- The Federal Community Mental Health Centers Construction Act of 1963, the seminal legislation of what would become known as deinstitutionalization, called for a network of community mental health centers (CMCHs) to provide services to people with mental illness. Optimism regarding the treatment effectiveness of the CMHCs led to a belief that they would eventually replace the state hospitals. Efforts to integrate the state and local systems of care thus became of secondary importance. States were often bypassed in the task of establishing community-care programs since localities generally dealt directly with the federal government in obtaining grants for the establishment of the

CMHCs (3, p. 3405). Yet the federal-local effort to establish community-care programs compounded coordination problems already complicating state-local efforts to transfer state hospital residents to appropriate community-based settings. This lack of synchronization produced a major housing crunch when the first wave of patients was released from the state hospitals and into communities that had, as yet, no place for many of them to live.

- Federal support for persons with mental illness who lived in the communities provided a powerful inducement for states to continue or to accelerate efforts to "close" their state hospitals. Many states felt continuing political and economic pressure to deinstitutionalize even when appropriate housing and support services would not necessarily be available to the state hospital residents released into the communities.

- Across the country, key court cases, such as Wyatt v. Stickney and Donaldson vs. O'Connor, mandated minimum levels of care in state hospitals, as well as treatment settings that were the "least restrictive." A whole body of law began to emerge that established the rights of mental health clients, especially during involuntary commitment proceedings. Newly implemented legal safeguards made state commitment laws increasingly stringent. States could no longer legally keep residents in state hospitals beyond a certain period--they had to be released, even to communities that had no real way to care for them.

- Federal aid programs serving individuals with psychiatric disabilities--Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)--have always had complicated application procedures and long waiting periods that are generally at odds with the timetables of hospital discharge policies (3, p. 3410). Many applicants may have to wait eight to 24 months for a determination, with as many as 80 percent of the applicants initially turned down. As a result, patients can be and often were released without any means of support. Moreover, a brief return to the state hospital can mean the loss of federal SSI and SSDI benefits.

- Many states found it politically and financially difficult to transfer to the communities the resources that had been with the patients in the state hospitals. Thus, communities did not have the initial resources they needed to establish many residential and support programs.

- Federal and state funds were generally channeled into separate service providers within the community-care system, exacerbating existing coordination problems.

Secondly, housing programs fell victim to local problems, which were and continue to be tremendously exacerbated by the chronic poverty of individuals with long-term mental illness. In many parts of the country, the tasks of finding suitable facilities in appropriate locations and of getting the clients settled in those facilities proved to be and continue to be particulary onerous.

- The vast majority of persons with mental illness would have to pay for their housing out of marginal federal aid benefits, often too limited even to allow them access to low-income housing. Among the scarce housing resources that did exist, many facilities were simply too expensive. In addition, individuals with psychiatric disabilities were in competition with other disabled groups, many of whom could offer a better financial deal.

- The rundown urban neighborhoods containing most of the potential housing stock for homes for persons with mental illness did not constitute an ideal location for individuals often singularly unable to defend themselves.

- The communities greatly resisted efforts to integrate persons with mental illness. Exclusionary zoning barred small group homes from many residential neighborhoods altogether. Larger facilities were kept from locating in better downtown neighborhoods through complicated and often discriminatory zoning regulations, requiring them to obtain zoning permits or variances. Requests for such permits or variances were frequently refused.

Thirdly, housing programs fell victim to some of the same misconceptions about the nature of mental illness that generally helped shape deinstitutionalization policies. At the beginning of the movement, many still believed that community-based care was the key to "curing" mental illness. Thus, many involved in deinstitutionalization planning failed to anticipate--and take the necessary steps to coordinate--the various service providers that would necessarily be involved in creating a truly comprehensive system of care in the community.

- Housing programs suffered when efforts to establish a continuum of community-based services failed. The absence of other community-care components greatly limited the placement success of persons with mental illness who did obtain some kind of basic housing. Without continuing mental health services, without a place to go during the day, without any kind of crisis assistance, many individuals deteriorated to where they could not remain in what had once been plausible housing arrangements.

- A general optimism about the benefits of community life led many involved in deinstitutionalization planning to simplify the complex housing needs of persons with mental illness. A continuum of housing programs would need to be developed to provide a range of short-term, transitional and long-term residential services.

The interplay of these various housing problems had dire consequences for individuals with mental illness. Many ended up back with their families, or in minimal service facilities such as board-and-care homes or single-room occupancy hotels. Others, overwhelmed with negotiating the complex service delivery system, soon found themselves trapped in the state hospital's "revolving door"--an alternating cycle of short-term hospitalizations and brief placements in the community. Or worse yet, whenever these tenuous arrangements gave way, more and more persons took their places among the homeless or the residents of the county jails.

Housing Shortages and Shortfalls Persist. Developments in the 1970s and 1980s have exacerbated the housing situation. At the present time, a greater number of individuals with mental illness are competing for each unit of possible housing. Moreover, in the housing that remains, rents have increased at a rate greatly exceeding income.

- Nearly one million single-room occupancy hotel rooms were destroyed between 1970 and 1982, as part of downtown renovation and urban renewal efforts. Roughly 33 percent of these rooms had been rented to persons with serious mental illness (4, p.4).

- Federal public housing programs have been substantially reduced. In 1980, Section 8 housing subsidies and public housing program funds amounted to $26.7 billion, with an additional $3.7 billion provided for the construction of new public housing; in 1983, $8.6 billion was provided for housing subsidies and funds, without any additional funds provided for the construction of new housing (5, p. 4). Two decades of inflation and unemployment have also produced burgeoning waiting lists for existing public housing. In New York City, the waiting list for public housing is estimated to be 18 years (6 p. 16).

- Federal funds for general mental health and social services have decreased, weakening those reciprocal parts of residential programs that depend on such services for their success.

- Federal programs such as the SSI Program help defray living expenses in residential facilities not covered by Medicaid. However, many persons with mental illness, intimidated by the complex application and eligibility process, do not apply. Today, only 12 percent of the individuals with serious mental illness who are eligible for SSI and SSDI actually receive benefits. (7, p. 28)

- Public prejudice against persons with mental illness remains a problem that often translates into action. While states have worked to combat exclusionary zoning ordinances, localities have begun to invoke the power of private land use regulations and restrictive covenants to block the establishment of community residences for individuals with psychiatric disabilities. In addition, a small percentage of the communities that did not or could not block the establishment of such residences during the last 20 years have been overrun by them, creating "social service ghettos" and entrenching resistance to individuals with mental illness in many remaining communities.

GENERAL LEGISLATIVE GUIDELINES

As an important component of community-care for individuals with mental illness, housing is a combination of critical elements. Not only is stable, affordable housing needed, but it must be linked with support services in order to be effective. As such, state legislators may want to consider the housing and support needs in an integrated fashion to maximize the state dollars they invest in community treatment and support programs.

Yet lawmakers would do well to remember that the housing needs of persons with mental illness are really no different from those of "normal" people: they need a roof over their heads and a support system they can turn to in times of trouble. Specifically, they need to be able to obtain help when they are in crisis, they need assistance making important transitions, and they need long-term, indefinite supports.

In brief, an adequate residential treatment program for persons with mental illness would include: affordable, low-income or subsidized housing; a location near support services and public transportation; a non-threatening community atmosphere encouraging independent living; linkage to a range of services, including crisis intervention, case management, vocational rehabilitation and socialization programs; and the continued availability of these critical services over time.

The continuum of residential services would include such transitional services as those listed below. It is important to note, however, that very few communities have this continuum of transitional programs.

- Group homes, providing 24-hour, highly-structured care for persons with serious mental illness who are not sick enough to be in the hospital, but whose history is marked by persistent, acute episodes and a failure to develop even basic living skills;

- Personal care homes, providing 24-hour supervision and structure for mildly to moderately disabled individuals who can hopefully make the transition to a less restrictive environment;

- Foster homes, providing a semi-supervised environment for small groups of clients who do not need around-the-clock supervision, but who are not yet ready for independent living in an apartment or house;

- Satellite housing, offering semi-independent living in apartments or houses for clients who still require some assistance meeting their basic living needs, but whose illnesses are largely in remission; and

- Family care homes, providing supervised placement in private homes for those who cannot withstand the stress of living with other individuals with mental illness.

Models for emergency assistance and crisis stabilization generally include respite apartments and crisis stabilization units, providing a highly structured and supervised program for the temporary care of those individuals who have achieved a certain degree of independence, but who are suffering a temporary crisis.

Increasingly, however, mental health administrators and advocates are turning away from the traditional residential models, which are often heavily congregated and staffed, incite the greatest community opposition and maximize the dislocation of the client. Instead, they are focusing on housing programs that provide stable living arrangements augmented by varying degrees of support. These programs can often be less expensive than the traditional models for residential care.

Beyond addressing gaps in the range of residential services available to persons with mental illness, state legislators can do much to promote adequate housing for this population in general. Lawmakers may want to consider action in the following areas:

- coordinating service providers, government agencies and funding sources;
- offering development incentives for public and private community residences;
- striving for equitable dispersion of residential facilities through pre-emptive zoning or site-selection laws;
- improving control and coordination of public and private residences through common regulations and standards;
- accelerating efforts to provide a continuum of community-based services, with housing as an integral part of the treatment process;
- involving consumers and family members in housing efforts, as they directly experience the strengths and weaknesses of a state's residential care program and can provide a very useful perspective;
- acknowledging that the housing problem is large and persistent and requires a long term commitment; and
- adopting a posture of hope and optimism for the future, as many lessons have been learned about how to care effectively for persons with mental illness.

THE STATES' RESPONSE IN RECENT YEARS

Zoning. State legislators have acted to address the housing needs of persons with mental illness in a number of ways. At least 37 states have passed laws, most since 1980, that prevent restrictive zoning and similar exclusionary practices against group homes serving persons with mental illness (8). Alabama, Colorado and Hawaii passed legislation in 1986 to prevent the exclusion of homes for individuals with psychiatric disabilities.

At least 25 states have removed local barriers by broadening the definition of a family to include inhabitants of group homes (8). California, Michigan, New Jersey (children only), New Mexico, South Carolina and Wisconsin are among those states that have overriden exlusionary zoning by stipulating that the residents of a group home constitute a "family" for residential zoning purposes. Other states prohibit ordinances that discriminate against individuals with mental illness in zoning matters.

- Oregon (1983 Or. Laws, Chap. 293) stipulates that a city or county may impose zoning restrictions on the operation or maintenance of a residential facility for persons with mental illness provided that they are no more restrictive than conditions imposed on similar residential dwellings in the same area.

- Texas (1985 Tex. Gen. Laws, Chap. 303) defines community homes for six or fewer disabled persons, including persons with mental illness, as a "permitted use" of a home in all residential and other zoning districts in the state, while rendering void any regulation or restriction on the use of the land relating to the transfer, sale or lease of the property.

In a similar vein, states have attempted to override local objections by protecting against the clustering of facilities. In 1985, for instance, Utah (1985 Utah Laws, Chap. 105) authorized the establishment of residential facilities for individuals with mental illness in all residential zones except those slated for single-family homes, but stipulated that such homes cannot be established within one mile of each other. Wisconsin overrode all local zoning in authorizing residential facilities serving children and adults with mental illness in all residential zones (1977 Wis. Laws, Chap. 205) in an attempt to force equitable dispersion of group homes.

Siting. States have also attempted to intervene in siting battles. New York established a specific site-selection process for group homes for persons with mental illness, involving both the group home operator and the local municipality (1978 N.Y. Laws, Chap. 468). Siting procedures that would have required such action as prior approval by the local legislative body (Connecticut) or written notice of intent to establish a group home provided to local citizen's groups and adjacent property owners (Maryland) were proposed, but did not pass, in 1985 and 1986.

Facilities. Other states have adopted legislation aimed at developing a range of residential facilities. Examples include:

- Arizona (1984 Ariz. Sess. Laws, Chap. 389) mandated the development of a statewide plan for a community residential treatment system, stipulating that the state may require no more than a 25 percent match of local or other funds in the establishment of a residential program;

- Hawaii (1980 Hawaii Sess. Laws, Act 221; 1985 Hawaii Sess. Laws, Act 219) provided guidelines for the establishment of a statewide system of residential treatment programs that provide a range of alternatives to institutional care;

- Louisiana (1981 La. Laws, Act 770) established a Community Residential Program Development Fund to provide loans to cover initial expenditures related to starting community residential programs;

- New York (1984 N.Y. Laws, Chap. 298) authorized the commissioner of mental health to establish a continuum of community residential services, outlining standards for the operation and funding of such facilities and providing up to 100 percent state reimbursement of certain costs associated with these programs; and

- Virginia (1986 Va. Acts, S.J.R. 53) requests that pilot projects be developed to: a) provide support to low-income families with a mentally disabled member who is at risk of institutionalization because of depletion of family resources; and b) use vacant state hospital buildings to provide a supervised domiciliary care center for clients with mental illness needing intensive supervision.

Client Support. Related legislation in Illinois and Rhode Island addressed the issue of client support in residential facilities. Illinois (1985 Ill. Laws, P.A. 94-918) aimed to secure and

maintain adequate financial benefits for those admitted to or released from a state hospital or a community residential program by requiring interagency agreements to that effect. Rhode Island (1982 R.I. Pub. Laws, Chap. 363) extended the legal protection already afforded persons with mental illness in institutions to the mentally disabled placed in community residential facilities.

Special Populations. States have also addressed the housing needs of specialized populations, especially those of children and homeless persons who are mentally ill. Examples include:

- Indiana (1984 Ind. Acts, P.L. 216) mandated the development of a plan for residential treatment programs for children who are emotionally disturbed or have substance abuse problems;

- New Jersey (1984 N.J. Laws, Chap. 180) authorized a program providing temporary rental or other housing assistance to persons who are homeless or in imminent danger of homelessness and encouraged increased availability of low-income housing through the provision of low-interest loans;

- New York (1981 N.Y. Laws, Chap. 947) authorized residential treatment facilities for children and youth organized around the principle of single port of entry and exit. The state also created the Homeless Housing and Assistance Program (1983 N.Y. Laws, Chap. 61), establishing separate funds for housing assistance to the homeless and for emergency shelter facilities, as well as a third, state-approved residential program for persons with mental illness: a residential care center for adults aimed to meet the housing needs of those individuals who are mentally ill and often homeless who cannot obtain appropriate placement in family care homes or in community residential programs (1985 N.Y. Laws, Chap. 351); and

- California (1987 Cal. Stats., Chap. 36) authorized local mental health programs to acquire or rehabilitate housing units for homeless mentally disabled persons. The act also allows housing units to be created for new emergency shelters when part of the housing services include transitional and long-term low-income housing services for persons with mental illness.

FUTURE IMPLICATIONS AND DIRECTIONS

During the upcoming 10 years, federal money for public housing, general social services and mental health services will probably continue to decrease. States are going to have to look increasingly within their own borders for the help they need. Many states already are taking steps to improve their public mental health systems, recognizing the importance of appropriate housing in the continuum of services. They are opting for small, scattered residential programs that minimize community resistance and client dislocation. They are redirecting state funds from the hospital to the community. They are taking steps to coordinate mental health services, thus working to ensure that the complementary elements of the community-based system are sufficiently in place to support one another. They are drawing up statewide blueprints for essential residential and other mental health services. They are directing resources toward problem populations--those who most often find themselves on the streets or in jail--in an effort to close daunting service gaps. And they are being rewarded.

Moreover, the courts, which have long taken part in the debate over housing for persons with mental illness have recently handed down some key decisions in support of community-based housing for this population. State supreme court cases have already been decided on both sides of the issue in California, Connecticut, Georgia, Iowa, Maine, Minnesota, Montana, Nebraska, New Hampshire, Ohio and Virginia. Yet advocates for persons with mental

illness are particularly hopeful that two 1985 federal court cases will help their cause in the future.

- In J.W. vs. City of Tacoma, Washington, 720 F.2d 1126 (9th Cr. 1983), the federal Ninth Circuit Court of Appeals ruled unconstitutional a local zoning ordinance that required an operator of a residential facility for former mental patients to obtain a special use permit when similar facilities for different residents could operate without a permit. The court held that the "Tacoma ordinance plainly discriminates' against former mental patients in that it singles them out for special treatment solely because of their medical history."

- In Living Centers vs. City of Cleburne, TX, 473 U.S., 87 L.Ed. 313, 106 S.Ct. 260 (1985), the U.S. Supreme Court struck down a local ordinance that required a special use permit for a proposed group home for the mentally retarded because the city could not prove that the home would "pose any special threats to the city's legitimate interests" beyond those posed by the boarding houses and hospitals that were already allowed to locate in the area without a permit.

Yet the years to come promise to bring increased demand. Problems with inadequate funding and integration of housing and support services can only increase with time. Moreover, inadequate benefits may keep many individuals with mental illness at a level where poverty--and not illness--place many potential places to live out of reach. Those who do find a place to call home may still have to face the stigma associated with mental illness: the community may not want them there. Thus state legislators will want to incorporate many different interests in their long-range efforts to solve the problem of housing for persons with mental illness.

REFERENCES

1. Manderscheid, Ronald W. National Institute of Mental Health. March 3, 1988: telephone interview.

2. "Redirecting State Dollars to Build Community-Based Mental Health Systems." Alpha Centerpiece: A Report on Health Policy Issues Washington, D.C.: Alpha Center, October 1986.

3. Legislative History of the Mental Health Systems Act of 1980 (P.L. 96-398). In United States Code: Congressional and Administrative News. St. Paul: West Publishing Company. 1980.

4. Stark, Louisa, president, National Coalition for the Homeless. "The Chronically Mentally Ill Homeless." Transcript of presentation at the 1985 NCSL Annual Meeting. Seattle, Washington, August 7, 1985.

5. "Report of the Work Group on the Homeless Mentally Ill." Sacramento, California. 1985.

6. Kozol, Jonathan. Rachel and Her Children: Homeless Families in America. New York: Crown Publishers, Inc., 1988.

7. U.S. Congress, House Committee on Government Operations, From Back Wards to Back Streets: The Failure of the Federal Government in Providing Services for the Mentally Ill. 100th Cong., 2nd sess., March 30, 1988.

8. Lublin, Joann S. "Group Homes that Serve the Mentally Ill Face New Barriers in Some Communities." The Wall Street Journal, December 16, 1986, p. 37.

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